SNYDER VOLUNTEER FIREFIGHTER'S BENEVOLENT ASSOCIATION, INC.
4531 MAIN STREET
SNYDER, NEW YORK 14226

REQUEST FOR ASSISTANCE/REIMBURSEMENT VOUCHER

Date of request: _____ Name of person making request: _____

Name of person to receive reimbursement: _____

Address of person receiving reimbursement: _____

_____

Date of Transaction/Procedure/Purchase: _____

Amount of actual out of pocket expense (***after insurance payment***): _____

Reason for purchase_____

_____

By signing this voucher, the undersigned hereby acknowledges a request for assistance from the Snyder Volunteer Firefighter's Benevolent Association and declares that he/she is not eligible to make claim, or to receive any other form of insurance, benefit, payment, reimbursement or consideration of payment for the request for assistance being sought.

X_____

Please return completed forms with the proper invoice or receipts to:
Snyder Volunteer Firefighter's Benevolent Association, Inc.
Attn: Thomas A. Merrill
4531 Main Street
Snyder, New York 14226

Board of Trustees Use Only Below This Line

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This request for assistance shall be approved for payment only upon the signature of five (5) members of the Board of Trustees of the Snyder Volunteer Firefighter's Benevolent Association, Inc.

This request for assistance has been reviewed by the undersigned five (5) members of the Board of Trustees.

1. _____ 2._____

3. _____ 4._____

5. _____

Approved: Yes _____ No _____ Date Approved: _____Date Paid: _____Amount Paid:_____

Bank: _____ Account: _____

Check No. _____ Bank Card No. _____

File Reviewed By Secretary - OK to consider claim_____ Check processed and mailed out_____

Complete this form when requesting assistance or reimbursement from the Snyder Volunteer Firefighter's Benevolent Association. The Board of Trustees will investigate each request and act in accordance with the Constitution and By-Laws of the Snyder Volunteer Firefighter's Benevolent Association, Inc. and the laws of the State of New York.

Before any request for assistance can be acted upon, it is necessary to ensure any and all insurance coverage has been applied for and utilized. Please be sure to include a copy of the insurance coverage paid out by all of your insurance companies.

The Benevolent Association can only assist members with out of pocket expenses associated with personal prescription medications (not over the counter) and other health care related expenses. All Insurance coverage must be clearly indicated. If there is no insurance coverage, please sign the declaration on the front of the form. **Claims must be submitted in a timely manner, not to exceed 90 days from the invoice or statement date; however, claims dated within the last 90 days of the year will only be accepted up until the following year's February trustees meeting.**

Note: All requests must include an invoice or a receipt for the payment requested. The Benevolent Association member's name must be clearly indicated on the receipt as the person receiving the health care procedure, medication, service or product.

Revised: March 2022